STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505017	A. Building B. Wing	01/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Washington Care Center	2821 South Walden Street Seattle, WA 98144

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure 17 of 18 staff members (Staff C, D, E, F, G, H, I, J, K, L, M, N, O, P, Q, R, and S) consistently implemented the facility's written infection control policies and procedures and follow standards of practice related to proper use of required Personal Protective Equipment (PPE), and the required isolation/transmission-based precautions when providing care and services to residents with known or suspected COVID-19 infection. Additionally, the facility failed to ensure [MEDICATION NAME] visitors were notified and educated of infection control practices /expectations while visiting in the facility with COVID-19 outbreak. These failures constituted a situation of an Immediate Jeopardy (IJ). On 01/06/2021, the facility was notified of an IJ related to CFR 483.80 F880, Infection Prevention and Control. On 01/22/2021, the validation of the IJ removal occurred through observations and review of records, including staff education, audits, staff schedules, employee screening logs, policies and procedures, and medical records. Findings include . CENTERS FOR DISEASE CONTROL (CDC GUIDELINES) According to the CDC, COVID-19 is an illness caused by [MEDICAL CONDITION] (Coronavirus) that can spread from person to person and through contact with contaminated surfaces. The CDC also stated that a person can become infected from respiratory droplets when an infected person coughs, sneezes or talks. The CDC guidelines for COVID-19 included the following: Residents with known or suspected COVID-19 should be cared for using all recommended PPE, which includes use of an N95 or higher-level respirator (or face mask if a respirator is not available), eye protection (such as goggles or a disposable face shield that covers the front and sides of the face), gloves, and gown. FACILITY POLICY (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	A review of facility policy titled, Special Droplet/Contact Precautions, dated 10/07/2020, showed that all facility staff, including doctors, essential support staff and [MEDICATION NAME] visitors, were to clean the hands, wear a surgical mask and face shield and be screened when entering the facility's main entrance to prevent the spread of respiratory viruses, including COVID-19. BREACH IN PPE USAGE and HAND HYGIENE Observations on first floor Unit, 2 EAST Unit, 2 WEST Unit and the third floor Unit on 01/05/2021 between 12:00 PM and 2:00 PM, and on 01/06/2021 between 5:00 AM and 8:00 AM, showed numerous staff with double masks in various configurations: an N95 mask over an N95 mask, a surgical mask over an N95 mask, a surgical mask over a surgical mask, cloth mask over a surgical mask. On 01/06/2021, observations throughout the facility, showed multiple staff on all facility units wearing improperly fitting N95 respirator masks, loose and without a seal, inconsistent with CDC guidelines which requires proper positioning of N-95 masks, the top strap to be positioned at the crown of the head, and the second strap positioned at the base of the neck and under the hair in order to fit and seal properly. In an interview on 01/06/2021 at 12:00 PM, Staff A, Administrator, stated that staff were double masking as a way of protecting the N95 mask to allow for prolonged use, as the facility did not have a sufficient supplies of the N95. 1st FLOOR Observation on 01/05/2021 at 12:35 PM, showed, Staff M, a Certified Nurse's Aide (CNA) provided care to COVID-19 positive residents. Staff M was observed wearing a N95 mask over another N95 mask, Staff M was observed with a top strap from one N95 mask strapped to the back of the neck , and the bottom strap from the second N95 mask, strapped to the back of his head. Staff M did not wear a face shield while serving lunch to COVID-19 positive residents. On 01/05/2021 at 12:40 PM, when asked what PPE he was taught to wear when providing care for COVID-19 positive resident, Staff M did not answer. Observation on 01/06/2021 at 5:10 AM, showed Staff C, a night shift Charge Nurse and Licensed Practical Nurse (LPN), provided care for COVID-19 positive residents and COVID-19 negative residents. A further observation showed Staff C wore double surgical masks (a surgical mask over a surgical mask). When asked, Staff C stated that he wore the double surgical masks, because the N95 mask was too tight and uncomfortable. When asked if he had been fit tested for the N95 mask. Staff C said, No. Similar observations were noted for Staff D, a night shift Nurse's Aide, who was working under the supervision of Staff C. Staff D was also assigned to COVID-19 positive residents and COVID-19 negative residents. Staff D was observed wearing a surgical mask and no face shield while providing care in the COVID-19 positive unit. On 01/06/2021 at 5:18 AM, Staff D stated that was the only mask she had and she did not know what a N95 mask was. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Observation on 01/06/21 at 6:40 AM, showed, Staff J, a Nurse's Aide, coming out of the elevator with two other staff members. Staff J was not wearing a mask or a face shield. Staff J did not implement social distancing and stood in close proximity (about two feet apart) while talking with other staff members. When asked, Staff J stated that the front desk receptionist was responsible for giving her the mask and shield, but the receptionist had not yet reported for work. Observation of the front desk on 01/06/2021 at 5:15 AM and 6:53 AM, showed, the receptionist sitting at the front desk with a couple boxes of N95 masks and surgical masks. DISINFECTION OF SHARED EQUIPMENT/ HAND HYGIENE Review of the facility's policy for infection control dated 10/07/2020, showed the facility used an approved disinfectant for cleaning of shared resident equipment. This policy showed staff were to wipe down shared equipment between each resident use to prevent spread of viruses that cause infections including COVID-19. Observation on 01/06/2021 at 6:30 AM, showed Staff M, a Nurse's Aide, was assigned to provide general resident care including taking vital signs of residents on a COVID-19 Positive unit. On 01/06/2021 at 6:40 AM, Staff M entered Room # 117 (a shared room) and took vital signs for Resident #3 and Resident #4. Staff M did not sanitize the vital signs machine between resident use. Staff M, then came out of the room, took off the gloves and, without washing his hands and disinfecting the vital sign machine, donned on a pair of clean gloves and proceeded to room [ROOM NUMBER] where he took vital signs for resident #8. On 01/06/2021 at 6:50 am, when asked Staff M stated, I know I'm supposed to wipe the vital signs machine with a disinfectant between residents, but I forgot UNIT 2 EAST (Designated COVID-19 POSITIVE UNIT) An observation on 01/06/2021 at 5:20 AM showed Staff E, a Nurse's Aide entered room [ROOM NUMBER] and provided resident care. Staff E wore a loosely fitting N95 without a seal around the rim of the mask, and was not wearing a face shield. After providing resident care, Staff E exited room [ROOM NUMBER] without removing the gloves. Staff E removed the gloves outside of the resident's room, inconsistent with the facility's policy and procedure for infection control dated July 2019 which instructed staff to remove and dispose all contaminated gloves in the resident's room before exiting. Staff E then proceeded, without performing any form of hand hygiene, donning on a clean pair of gloves, entered Room # 213, and provided care without wearing a face shield. On 01/06/2020 at 5:20 AM, when asked, what training he received related to COVID-19 infection, Staff E stated that he was an agency nurse's aide, and it was his first day to work in the nursing home. Staff E stated that he had not received any education before beginning of the shift. When staff E was asked why he was not wearing a face shield, he stated, I did not know I was supposed to wear one. On 01/06/2021 at 5:30 AM, Staff F, a Registered Nurse (RN), acknowledged he did not provide any education to Staff E prior to beginning of the shift. Staff F stated that he thought Staff E had already been educated. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On 01/06/2021 at 12:00 PM, Staff A, the Administrator, confirmed Staff E had not received education related to COVID-19 infection, or any orientation prior to providing resident care on the COVID-19 positive unit. Staff A stated that the facility did not have a system in place to provide orientation to agency staff, and that the facility was working on implementing a system to educate and orient agency staff prior to assigning residents to them. Observation on 01/05/2021 at 12:30 PM, showed Staff N, Occupational Therapist (OT) walking in the facility hallway toward the main entrance, wearing a surgical mask, and no face shield. When asked, Staff N stated, I just came from my lunch break, I'm supposed to have the face shield on, but I forgot. Observation on 01/05/2021 at 12:38 PM, showed staff O, Central Supplies staff, delivered resident care supplies while wearing a surgical mask, and no face shield. When asked, he said he forgot. Observation on 12/05/2021 at 1:00 PM, showed Staff P, CNA, entered room [ROOM NUMBER] and delivered a lunch tray for the resident. Staff P wore a surgical mask, but was not wearing a face shield before entering the resident's room. When asked, he stated that he left the face shield at the nurse's station. Observation on 01/05/2021 at 1:10 PM, showed Staff Q, Restorative Aide, entering the facility main entrance after accompanying Resident #5 to a doctor's appointment outside the facility. Staff Q was wearing a cloth mask over a surgical mask, but did not have a face shield on. Observation on 01/06/2021 at 6:35 AM, showed Staff L, CNA, exiting the COVID- 19 positive unit (2 East Unit), a designated COVID-19 positive Unit. Staff L took off the gloves and isolation suit at the designated area. With the contaminated face shied and face mask still on, Staff L proceeded to the clock out area while interacting with oncoming staff. Staff L proceeded to the 1st floor, took off the face shied and threw it in a nearby garbage can. With a contaminated mask on, she exited the facility. Staff L's actions were inconsistent with the facility's policy for infection control and CDC guidelines which instruct staff to dispose of contaminated PPE on exit from COVID-19 positive unit, to prevent the spread of [MEDICAL CONDITION]. 2 WEST Observation on 01/06/21 at 6:15 AM, showed Staff K , a Nurse's Aide, wore double masks (surgical mask over N95 mask). When asked, Staff K stated that she wore two masks for more protection in case the resident was coughing while providing care, or another staff member was coughing nearby. 3rd FLOOR (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Observation on 01/05/2021 at 12:45 PM, showed room [ROOM NUMBER] with two residents (#2 and #7) positive for COVID-19. There was an isolation cart outside the residents' room including signage instructing staff to wear full PPE (N95 mask, isolation gown, face shield and gloves)before entering the room to provide resident care. Staff G was assigned to provide care for COVID-19 positive residents in Room # 320 and other residents who did not have COVID-19 infection on the same unit. Observation on 01/06/2021 at 5: 28 AM, Staff G, a Nurse's Aide, entered a COVID-19 positive room (#320) to provide care. Staff G wore a surgical mask and with no face shield. On 01/06/2021 at 6:35, in an interview, Staff G stated that she always used a surgical mask and no face shield when providing care for COVID-19 positive residents or COVID-19 negative residents. Observation on 01/05/2021 at 12:45 PM, showed Staff S, Dietary Aide, delivered snacks for the residents on the unit with COVID-19 outbreak. Staff S wore a cloth mask and did not have a face shield. When asked, Staff S stated that he was aware of the N95 mask and face shield requirement, and that he could not wear them because they were uncomfortable. Observation on 01/06/2021, at 5: 55 AM, showed Staff I, a Nurse's Aide, wore a surgical mask over a N95 mask. When asked, Staff I stated that she covered the N95 mask with a surgical mask to protect and extend the use of the N95 mask. Observation on 01/06/2021 at 5: 48 AM, showed Staff H, LPN, was assigned to provide care for COVID-19 positive residents in room [ROOM NUMBER] as well as the rest of the residents on the unit who were COVID-19 negative. Staff H wore a surgical mask over a N95. On 01/06/21 at 6.05 AM, Staff H stated that she wore the surgical mask over the N95 mask for more protection and prolonged use of the N95 mask. FAILURE TO EDUCATE VISITORS Observation on 01/05/2020 at 12:47 PM, showed Resident #6 (a hospice resident) sitting close to a family member ([MEDICATION NAME] visitor) less than 6 feet apart having a meal together. Further observation showed, approximately 15 minutes later, Resident #6's family member was observed wearing a cloth mask without a face shield, assisting Resident#6 to ambulate to the weight room across from Resident #6's room. The resident was not wearing a face mask, a face shield or gloves. The resident's family member was observed holding the resident's hand while assisting the resident to ambulate to the weight room. On 01/05/2021 at 1:00 PM, when the resident's family member was asked if the facility educated her about required PPE usage while she visited the resident, she said No. On 01/05/2021 at 1:30 PM, when Staff R, Social Worker (SW), was asked, Staff R was unable to provide documentation to show the facility educated the family member about the required PPE usage during visits. On 01/05/2021 at 1;45 PM, In an interview, Staff T, LPN, was asked how he ensured Resident #6's family member followed infection control practices related to COVID-19, while visiting Resident #6. Staff T stated that he was not aware Resident #6 was scheduled for a visit. On 01/06/2021 at 12:00 PM, Staff A stated that the facility was working on developing a system to educate visitors about infection control practices during in-room visits. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Review of the facility's infection control line listing, showed, that the COVID-19 outbreak started on 12/04/2020 with a single active case. As of 01/06/2020, a total of 54 residents and 21 staff had since tested positive for COVID-19, and eight residents infected with COVID-19 passed away. in an interview on 01/06/2021 at 1:00 PM, when asked about the root cause of the spread of COVID-19 infection, Staff A stated that the facility had not completed a root cause analysis of the spread the infection of COVID-19 yet, one month since the COVID-19 outbreak. The failure to identify the root cause of the spread of the COVID-19 infection and implement interventions based on identified root cause to prevent further spread of infection, placed all residents and staff at risk for contracting the dangerous [MEDICAL CONDITION] resulting in serious health complications and or death. REFERENCE: WAC 388-07-1320(1)(a)(c).